

## **5. HOME HEALTH SERVICES**

This section describes Medicaid's coverage of Home Health Services. It tells you about:

- What Home Health Covers – See 5.1, page 5-2
- Who's Covered – See 5.2, page 5-4
- Limitations – See 5.3, page 5-6
- Who May Provide Home Health – See 5.4, page 5-7
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- Recertification Review – See 5.9, page 5-11
- Getting Paid – See 5.10, page 5-11

At the end of this section are some of the questions often asked about Home Health Services and the answers to those questions. See Home Health Services Q & A (page 5-27).

### 5.1 What Home Health Covers

Home Health covers the following services when they are medically necessary to help restore, rehabilitate or maintain a patient in the home and the patient's home is the most appropriate setting for the care:

- Skilled Nursing
- Physical Therapy
- Speech-Language Pathology
- Occupational Therapy
- Home Health Aide Services
- Medical Supplies

Home Health skilled services (skilled nursing, physical therapy, speech-language pathology and occupational therapy) and aide services are for patients who reside in private residences. Patients residing in an adult care home (such as a rest home or family care home) may receive the home health skilled services – they may not receive home health aide services. Medical supplies are available to patients in private residences and adult care homes. Home health skilled services and aide services are provided on a visit basis. A description of each service follows.

**NOTE:** See the *MEDICARE-Medicaid Skilled Services Billing Guide* beginning on page 5-15 for additional details on covered services.

#### 5.1.1 Skilled Nursing

Skilled nursing visits are provided by a licensed registered nurse (RN) or by a licensed practical nurse (LPN) under the direction of a licensed RN. Services must be reasonable and necessary to the diagnoses and treatment of the patient's illness or injury. The services include:

- Observation and assessment of the patient's condition when only the specialized skills of a medical professional can determine the patient's medical status.
- Management and evaluation of the patient's plan of care to ensure that the care is achieving its purpose.
- Teaching and training the patient, the patient's family, or other caregivers how to manage the patient's treatment regimen.
- Skilled nursing procedures that are reasonable and necessary to the treatment of the patient's illness or injury.

#### 5.1.2 Physical Therapy

Physical therapy services are provided by a licensed physical therapist (PT) or by a licensed physical therapy assistant under the direction of a licensed PT. These services help relieve pain, restore maximum body function and prevent disability following disease, injury or loss of a part of the body.

#### 5.1.3 Speech-Language Pathology

Speech-language pathology and audiology services are provided by a licensed speech-language pathologist or audiologist to diagnose and treat speech and language disorders that result in communication disabilities. The services are also provided to diagnose and treat swallowing disorders (dysphagia), regardless of the presence of a communication disability.

#### 5.1.4 Occupational Therapy

Occupational therapy services are provided by a licensed occupational therapist (OT) or by a licensed occupational therapy assistant under the direction of a licensed OT. Services help improve and restore functions impaired by illness or injury. When a patient's functions are permanently lost or reduced, occupational therapy helps improve the patient's ability to perform the tasks needed for independent living.

#### 5.1.5 Home Health Aide Services

Home health aide services help maintain a patient's health and facilitate treatment of the patient's illness or injury. Typical tasks include:

- Assisting with activities of daily living (bathing, caring for hair and teeth, eating, exercising, transferring and elimination assistance).
- Assisting a patient in taking self-administered medications that do not require the skills of a licensed nurse to be provided safely and effectively.
- Assisting with home maintenance that is incidental to a patient's medical care needs, such as light cleaning, meal preparation, taking out trash and grocery shopping.
- Performing simple medical duties such as taking a patient's temperature, pulse, respiration and blood pressure; weighing the patient; changing dressings that do not require the skills of a licensed nurse; and reporting changes in the patient's condition and needs to appropriate parties.

#### 5.1.6 Medical Supplies

Medical supplies include those items listed in the Medicaid Home Health fee schedule. An item is covered when it meets the following criteria:

- The supply is medically reasonable and necessary for treatment of a patient's illness or injury. The supply has a therapeutic or diagnostic purpose for a specific patient.

**NOTE:** *This requirement excludes billing for items furnished for comfort or convenience. Items that are often used by persons who are not ill or injured – such as soaps, shampoos, lotions and skin conditioners—are not covered.*

- The physician specifically orders the supply in the plan of care.

**NOTE:** *A physician's order in itself does not make an item "medically necessary" in the context of Medicaid coverage. The order allows you to bill for the item if it meets Medicaid criteria.*

- The supply is an item not routinely furnished as part of patient care. Minor medical and surgical supplies routinely used in patient care such as alcohol wipes, applicators, lubricants, thermometers and thermometer covers are not billed individually to Medicaid. These items are considered part of an agency's overhead costs.
- The supply is considered a Home Health supply by Medicaid. Items such as drugs and biologicals, medical equipment, orthotics and prosthetics, and nutritional supplements are examples of items not considered Home Health supplies.

The Home Health fee schedule includes HCPCS Code W4655 “Covered Supplies Not Elsewhere Classified” to allow you to bill for non-listed items that meet Medicaid’s coverage criteria. Though the list of supplies on the fee schedule is periodically updated, it cannot include every covered supply item. When you are considering the use of W4655:

- Determine whether the item meets the Medicaid criteria outlined above; and
- Determine whether the item is not elsewhere classified – that is, the supply is not on the Durable Medical Equipment (DME) fee schedule (including DME-related supplies) or the Home Infusion Therapy (HIT) fee schedule, and does not have an existing code on the Home Health fee schedule.

### 5.2 Who’s Covered

Whether a patient is covered depends on three factors:

#### 5.2.1 Type of Medicaid Coverage

A patient must be covered under:

- Regular Medicaid coverage – that is, have a **BLUE** card; or
- Pregnant Women (MPW) coverage – that is, have a **PINK** card and require a home health service due to a pregnancy-related condition. Prior approval is required – see 5.3.1.

**NOTE:** *If a patient is a Medicaid managed care participant, a Hospice patient or a CAP client, coverage may be affected. See Section 2 for more information.*

#### 5.2.2 Patient’s Medical Needs

Home Health Services must be medically reasonable and necessary for the treatment of a patient’s illness or injury. The need for each service is documented by the physician who orders the service. See Step 1 in 5.5.

#### 5.2.3 Whether the Service is Medically Necessary and Appropriate in the Home

Home Health skilled services and home health aide services must be medically necessary and the patient’s home must be the most appropriate setting for the care.

**REMEMBER:** *Home health aide services may not be provided to a patient in an adult care home.*

Home Health skilled and home health aide services are medically necessary and appropriate when the patient’s medical records accurately justify a medical reason that the services should be provided in the patient’s home instead of a physician’s office, clinic, or other out-patient setting, according to one or more of the following guidelines:

- a. Because of the patient’s illness, injury, or disability, going to a physician’s office, clinic, or other out-patient setting for the needed service would create a medical hardship for the patient. Any statement on the plan of care regarding such medical hardship must be supported by the totality of the patient’s medical records.

*Examples of medical hardship include:*

- *A patient who requires ambulance transportation,*
- *A patient in severe pain,*
- *A patient with bilateral upper extremity loss who is unable to open doors, use handrails or perform other activities, and needs help to leave his residence.*
- *A patient for whom leaving the home is likely to cause an exacerbation of his condition, and*
- *A patient who experiences shortness of breath that significantly hinders travel*
- *A diabetic patient is wheelchair bound due to bilateral BK amputations and makes only infrequent trips from his residence because of medical complications.*

*Some examples of conditions that in themselves are not considered creating a medical hardship include the need to use portable oxygen, walking with a limp, or the need to use an assistive device such as a cane, walker or wheelchair. A wheelchair-bound patient who regularly drives a specially equipped vehicle to travel outside of the home is not considered to have a medical hardship. The need for routine transportation is not considered a medical hardship – assistance with transportation to medical appointments is available through the county departments of social services. The common need for a child to be supervised by an adult when outside the home also does not in itself justify providing care in the home.*

- b. Going to a physician's office, clinic, or other out-patient setting for the needed service is contraindicated by the patient's documented medical condition. The patient's condition is so fragile or unstable that the physician states that leaving the home is undesirable or detrimental under the circumstances.

*Examples include:*

- *A newborn infant up to six weeks of age who has acute care needs or who is at medical risk,*
- *A patient just had surgery and has resultant weakness and pain. Because of her condition, her physician restricts certain activities and allows getting out of bed for only a short period of time.*
- *A patient with severe arteriosclerotic heart disease must avoid all stress and physical activity.*
- *A patient with a medical condition that requires protection from exposure to infections, and*
- *A patient who is just out of the hospital after major surgery*

- c. Going to a physician's office, clinic, or other out-patient setting for the needed service would interfere with the effectiveness of the service.

*Examples include:*

- *A young child who would not benefit from out-patient therapy because of extreme fear of the hospital where the out-patient setting is located;*
- *A patient living in an area where travel to out-patient therapy would require an hour or more travel;*

- *A patient who needs a service repeated at frequencies that would be difficult to accommodate in the physician's office, clinic, or other out-patient setting, such as daily IV infusions or daily insulin injections;*
- *A patient who needs regular and prn catheter changes and having Home Health in place will prevent emergency room visits for unscheduled catheter changes due to dislodgment or blockage;*
- *A patient who, because of the patient's illness, injury or disability, including mental disorders, has demonstrated past failure to comply with going to a physician's office, clinic, or other out-patient setting for the needed service, and has suffered or has a high probability of suffering adverse health consequences as a result, including use of emergency room and hospital admissions.*
- *A patient who is newly diagnosed with end stage renal disease has been prescribed a specialized diet with severe restrictions. Due to the patient's limited ability to understand from standard diet teaching only, it is necessary for the nurse to teach in the home to use examples of foods available to the patient. It will also be necessary to teach and train the caregivers in the home who will prepare the food. Attempting the teaching outside of the home setting would interfere with the effectiveness of teaching this patient and caregivers.*
- *A patient has an abdominal wound dehiscence. The wound care is extensive and requires irrigation and packing twice a day. The care will be accomplished by the patient's caregivers. The caregivers need to observe the nurse performing the dressing changes more than once for teaching and they need to be observed by the nurse for assessment of understanding. They also need to learn sterile technique and how to prepare a sterile field in the home environment. Due to the extensive teaching needed, along with observation, teaching is most effectively accomplished in the home.*
- *A patient who requires use of assistive devices specifically customized for the patient's home environment (bath chairs, shower grab bars) requires training on the use of those devices in the home for the training to be effective.*

**REMEMBER:** Home Health Services may be delivered only at the patient's residence.

### 5.3 Limitations

#### 5.3.1 Prior Approval

Prior approval is not required unless the patient has a PINK card, which indicates MPW coverage. See 5.5, Step 2, to learn about prior approval for MPW patients.

#### 5.3.2 Amount of Service

The amount of Home Health Services available to a patient is limited to what is medically necessary as determined by Medicaid policies. In addition, the following limitations apply:

- **Skilled Nursing and Home Health Aide Services** must be part-time or intermittent.

**Part-time** means:

- Skilled nursing visits and/or home health aide visits are made up to seven days per week; and
- The total time spent in skilled nursing visits and home health aide visits does not exceed eight hours per day and 34 hours per week.

**Intermittent** means either:

- Skilled nursing visits and/or home health aide visits are not made each day of the week and the total time spent in those visits in a week is 34 hours or less; or
- Skilled nursing visits and/or home health aide visits are made each day of the week and the time used for the visits each day is not more than eight hours.

**REMEMBER:** Though Medicaid pays for skilled nursing and home health aide by the visit, you have to track hours to comply with the above limits.

- **Skilled Nursing Visits** for certain activities are limited as described on the MEDICARE – Medicaid Skilled Services Billing Guide beginning on page 5-15

### 5.3.3 Other Limitations

- **Home Health Aide Visits** are for only those patients who receive Medicaid-covered skilled home health services. Patients who require only aide services may be referred for Personal Care Services (PCS). See Section 6 for information on PCS.
- **Medicaid payment is restricted** in relation to the following services:
  - **Hospice Care:** A patient receiving Hospice under Medicaid or Medicare may not receive Home Health Services related to the treatment of the terminal illness. If a patient meets the requirements of both services, he may choose which service he wishes to receive in relation to the terminal illness.
  - **Personal Care Services (PCS):** A patient may not receive home health aide services and PCS on the same day.

See 5.6 for guidance on coordinating with other services.

**REMEMBER:** Participation in a Medicaid managed care program or CAP may also affect coverage.

## 5.4 Who May Provide Home Health

You may provide Home Health Services if you are a Medicare-certified home health agency that is enrolled with DMA as a home health provider.

## 5.5 Getting Coverage

The following outlines the basic steps for a patient to get Home Health Services. The steps are in the order that they are usually accomplished.

### Step 1 Receive Physician Orders (HCFA-485)

A patient's physician identifies the need for Home Health Services and provides signed, written orders that detail the needed services. The home health nurse or appropriately qualified health professional assists in developing the orders. The documentation must establish that the ordered services are medically necessary and the patient's home is the most appropriate setting for the care. All of this information is written on a plan of care (HCFA-485).

The HCFA-485 must show:

- All pertinent diagnoses, including the patient's mental status;
- The types of services, supplies and equipment ordered – including the types and frequency of visits;
- The prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications and treatments;
- A statement that patient's home is the most appropriate setting for the care.;
- Safety measures to protect against injury; and
- Discharge plans.

If the physician asks for services to begin before your agency receives written orders, you may act on the physician's verbal orders. The verbal orders must be written on the HCFA-485 by a licensed nurse or other appropriate home care professional in accordance with Home Care Licensure Rules.

### **Step 2     Verify Medicaid Eligibility**

Follow the steps in Section 3 to verify Medicaid eligibility. When checking the color of a patient's Medicaid ID card, remember the following:

**Blue:** A patient may be considered for Home Health Services.

**Pink:** Covers only pregnancy related services as defined in 2.14. Home Health Services must be related to the pregnancy and must have prior approval in order to be covered. Before providing services to a patient with a PINK card, get prior approval by following the procedures in Appendix E.

**Buff:** A patient is not eligible for Home Health Services that are covered only by Medicaid.

**REMEMBER:** Check all other key information on the card – such as eligibility dates, insurance information and other important items noted in Section 3. If the card shows that the patient participates in a Medicaid managed care program or Hospice or CAP, coverage may be restricted. See 5.3.3 and Section 2. Also, if the patient's situation indicates possible Hospice participation, check AVR for Medicaid Hospice participation. See Appendix D.

### **Step 3     Assess Appropriateness**

As you consider providing a service, review the available information to see if the service appears appropriate for Medicaid coverage. Key points are:

- **Does the patient have a medical necessity for the service?** A patient must be under the care of a physician who certifies that the service is needed.
- **Is the service to be provided in the patient's home?** A patient must reside in a private residence or an adult care home in order to receive home health skilled services or medical supplies. For home health aide services, a patient must reside in a private residence.
- **If a skilled service or home health aide service, is the patient's home the most appropriate setting for the service?** Using the guidance in 5.2.3, determine if the

patient's home is the most appropriate setting for the service or if the need could be met in another setting such as a physician's office, clinic or outpatient facility.

- **Are other sources of care available?** Look at available care from other sources. Consider the help from family members and others who are capable, willing and able to provide care.
- **Are there possible conflicts with other services?** Note possible conflicts that would interfere or detract from providing Home Health Services. Note the restrictions in 5.3 and the guidance on service coordination in 5.6.
- **Should Medicare, other third parties or Medicaid pay the service?** If Medicare or another possible payer covers a patient, determine whether that payer will cover the service before you bill Medicaid. Use the guidance in 5.10.1 and the *MEDICARE-Medicaid Skilled Services Billing Guide* to help make the decision for Medicare patients.

#### **Step 4     Resolve Questions and Concerns**

Resolve any questions or concerns you have about a patient's care before starting services. If anything that is ordered by the physician appears inappropriate or a potential source of problems, contact the physician.

### **5.6     Coordinating Care**

You are responsible for knowing what other services are being received by your patient. Coordinate services to ensure the best care for the patient while avoiding duplication or overlap.

- **Private Duty Nursing (PDN):** Your coordination for a PDN patient depends upon the service.
  - **Therapy Services:** You may provide visits for physical therapy, speech-language pathology services and occupational therapy during the same time period a patient receives PDN.
  - **Skilled Nursing Visits:** Usually a PDN patient should not require a skilled nursing visit. The only reason to make a visit to a PDN patient is to provide care or treatment outside of the hours covered by PDN or to make an assessment for provision of medical supplies.
  - **Home Health Aide Visits:** Do not provide a home health aide visit during the same hours a patient is receiving PDN services.

**REMEMBER:** *Home Health Aide Services are available only to those patients receiving a skilled home health service.*

**NOTE:** *PDN providers may furnish the medical supplies needed by the patient. If supplies are the only service that you are requested to furnish to a PDN patient, consider having the PDN agency provide and bill for the items.*

See Section 9 for information about PDN.

- **PCS and Home Health Aide Visits:** Do not provide a home health aide visit on the same day that a patient receives PCS. See Section 6 for information about PCS.
- **Home Infusion Therapy (HIT):** Your coordination responsibilities depend upon the type of infusion therapy being received by the patient under Medicaid's HIT coverage.

- **Drug Therapies:** Medicaid covers HIT drug therapies as a package. Do not provide services related to the provision of a drug therapy. If you are providing visits for other medical needs, coordinate your visits with the HIT provider to avoid two or more individuals attempting to work with the patient at the same time. If skilled nursing visits are needed, the HIT nurse and the home health nurse may be present at the same time to coordinate care; however, the subsequent visits to provide care should be done at different times.
- **Nutrition Therapies:** You may provide the required skilled nursing care for enteral or parenteral nutrition therapy. DME suppliers and HIT providers may furnish the equipment, supplies and formulae needed for enteral nutrition. Only HIT providers may provide these items for parenteral nutrition.

See Section 7 to learn about HIT.

- **Hospice:** Do not provide services related to the terminal illness. You may provide services only for an illness or injury not related to the terminal illness. See Section 8 for information on Hospice.

### 5.7 Delivering and Supervising Care

Provide Home Health Services according to the physician's orders, as documented on the HCFA-485. Make sure that your services are provided and supervised according to applicable laws, regulations and good practice. Coordinate the care, including any needed changes, with the patient's physician. If providing home health aide services, the appropriate professional provides supervision with supervisory visits to the patient's home every two weeks. A RN must supervise the aide if the patient is receiving skilled nursing care. If the patient is not receiving skilled nursing care, but is receiving another skilled service (physical therapy, occupational therapy, or speech-language pathology services), the appropriate therapist may provide supervision.

Keep the following in mind when planning visits:

- A visit begins when a service is initiated and does not end until the delivery of that service is finished. A service is to be completed during a single visit.
- When a patient needs multiple services from a nurse, therapist or aide and all of the services can be performed during the same visit, complete all the services in only one visit.

**Example 1:** A home health nurse visits a patient to provide IV therapy. Because of the extended time needed to administer the IV, the nurse starts the IV, leaves the home and returns later to stop the process. This is one skilled visit because the administration of the IV is considered one service.

**Example 2:** A patient requires a nurse to observe and evaluate a surgical site, teach sterile dressing techniques, perform a sterile dressing change and perform venipuncture for lab studies. Since all of these services can be performed in one visit, only one visit is scheduled.

**Example 3:** A patient is 10 days post-op after a left above-the-knee amputation. A nurse is needed twice a day (a.m. and p.m.) to change the stump dressing. Two skilled nursing visits per day may be billed because a separate service is completed during each visit.

**NOTE:** Do not bill Medicaid for a visit made only to supervise staff.

## 5.8 Changing the Plan of Care

Any change in the frequency or number of services provided during a certification period must be authorized by the physician before you implement the change. The physician's orders may be verbal or written. Verbal orders are documented and signed by the physician according to Home Care Licensure Rules.

## 5.9 Recertification Review

The physician must recertify a patient's need for Home Health Services every 60 days. If the patient needs home health beyond the current certification period, a new HCFA-485 must be signed by the physician.

## 5.10 Getting Paid

Instructions for filing claims are in Section 14. Below are the key points to keep in mind when filing home health claims.

### 5.10.1 What May Be Billed

You may bill for services ordered by the physician and provided to the patient according to Medicaid policies and procedures. Use the following instructions along with the *MEDICARE-Medicaid Skilled Services Billing Guide* beginning on page 5-15.

**Skilled Nursing Visits:** When determining whether to bill a skilled nursing visit to Medicaid, consult the *MEDICARE-Medicaid Skilled Services Billing Guide*. HCPCS codes are required to describe each nursing visit billed to Medicaid beginning with 2/1/2000 date of service.

**REMEMBER:** Do not use HCPCS codes for dates of service prior to 2/1/2000

- **If the patient is Medicaid only** – All of the skilled nursing services in the Guide may be billed to Medicaid if the visit meets all other Medicaid requirements. If you provide a skilled nursing service not listed in the Guide and you can document that it meets Medicaid criteria and requirements, use the appropriate revenue code and maintain documentation supporting your decision.

*For 2/1/2000 and after dates of service*, use the appropriate revenue code plus the applicable HCPCS code from the Guide. If you provide a skilled nursing service not listed in the Guide and you can document that it meets Medicaid criteria and requirements, use the appropriate revenue code plus HCPCS code W9958, "Skilled Nursing Visit Not Elsewhere Classified" and maintain documentation supporting your decision.

- **If the patient has Medicare and is homebound** – If the patient has Medicare and meets Medicare homebound requirements, follow the instructions in that column of the Guide.
  - If "BILL MEDICARE " is in the column, you must bill Medicare for the service. If a properly prepared and submitted Medicare claim is denied and the service meets Medicaid criteria, you may bill Medicaid using the appropriate revenue code.

*For 2/1/2000 and after dates of service*, use the appropriate revenue code plus HCPCS code W9959, "Skilled Nursing Visit Denied by Medicare or Patient Not Homebound."

Maintain documentation, including a copy of the denied Medicare claim and the Medicare EOB, to support billing Medicaid.

- If “*You may bill Medicaid...*” is in the column, you may bill Medicaid without billing Medicare first. Use the appropriate revenue code.

*For 2/1/2000 and after dates of service, use the appropriate revenue code plus the specified HCPCS code.*

For these situations, you do not have to maintain documentation to justify that Medicare does not cover the service.

- If you encounter a situation that is not listed in the Guide, make a reasonable decision about billing Medicare or Medicaid. If you can document that the service is not covered by Medicare, but meets Medicaid criteria and requirements, use the appropriate revenue code.

*For 2/1/2000 and after dates of service, use the appropriate revenue code plus HCPCS code W9958, “Skilled Nursing Visit Not Elsewhere Classified.”*

Maintain documentation to substantiate your decision.

- ***If the patient has Medicare and is not homebound*** – If the patient has Medicare and does not meet Medicare homebound requirements, you may bill Medicaid without billing Medicare first. Follow the instructions in that column of the Guide. Maintain documentation to support the determination that the patient is not homebound.

**Physical Therapy Visits:** When deciding whether to bill a physical therapy (PT) visit to Medicaid, consult the *MEDICARE-Medicaid Skilled Services Billing Guide*. HCPCS codes are not required for billing PT. Whenever you bill Medicaid for a dually-eligible patient, you are stating that you are billing for only those services allowed by Medicaid policy as described in the Guide.

- ***If the patient is Medicaid only*** – All of the physical therapy services in the Guide may be billed to Medicaid if the visit meets all other Medicaid requirements. Use revenue code 420.
- ***If the patient has Medicare and is homebound*** – If the patient has Medicare and meets Medicare homebound requirements, follow the instructions in that column of the Guide.
  - If “BILL MEDICARE” is in the column, you must bill Medicare for the service. Medicaid may not be billed.
  - If “*You may bill Medicaid...*” is in the column, you may bill Medicaid without billing Medicare first. Use revenue code 420. For these situations, you do not have to maintain documentation that Medicare does not cover the service.
- ***If the patient has Medicare and is not homebound*** – If the patient has Medicare and does not meet Medicare homebound requirements, you may bill Medicaid without billing Medicare first. Follow the instructions in that column of the Guide. Maintain documentation to support the determination that the patient is not homebound.

**Occupational Therapy Visits:** The only difference between Medicare and Medicaid coverage of Home Health occupational therapy (OT) is Medicare’s “qualifying service” requirement and the Medicare homebound requirement. Medicaid does not require a qualifying service for OT – the need for OT may be established separate from other skilled home health services – and Medicaid does not have a homebound requirement. HCPCS codes are not required for billing OT. Whenever you bill Medicaid for a dually-eligible patient, you are stating that you are billing for only those services allowed by Medicaid policy as described in the Guide.

- **If the patient is Medicaid only** – The occupational therapy services described in the Guide may be billed to Medicaid. Use revenue code 430.
- **If the patient has Medicare and is homebound** – If the patient has Medicare and meets Medicare homebound requirements, follow the instructions in that column of the Guide.
  - If “BILL MEDICARE” is in the column, you must bill Medicare for the service. Medicaid may not be billed.
  - If “You may bill Medicaid...” is in the column, you may bill Medicaid without billing Medicare first. Use revenue code 430. Your documentation must show that there is no qualifying Medicare skilled service.
- **If the patient has Medicare and is not homebound** – If the patient has Medicare and does not meet Medicare homebound requirements, you may bill Medicaid without billing Medicare first. Follow the instructions in that column of the Guide. Maintain documentation to support the determination that the patient is not homebound.

**Speech-Language Pathology Visits:** When deciding whether to bill a speech-language pathology visit to Medicaid, consult the *MEDICARE-Medicaid Skilled Services Billing Guide*. HCPCS codes are not required for billing speech-language pathology. Whenever you bill Medicaid for a dually-eligible patient, you are stating that you are billing for only those services allowed by Medicaid policy as described in the Guide.

- **If the patient is Medicaid only** – All of the speech-language pathology services in the Guide may be billed to Medicaid if the visit meets all other Medicaid requirements. Use revenue code 440.
- **If the patient has Medicare and is homebound** – If the patient has Medicare and meets Medicare homebound requirements, follow the instructions in that column of the Guide.
  - If “BILL MEDICARE” is in the column, you must bill Medicare for the service. Medicaid may not be billed.
  - If “You may bill Medicaid...” is in the column, you may bill Medicaid without billing Medicare first. Use revenue code 440. For these situations, you do not have to maintain documentation that Medicare does not cover the service.
- **If the patient has Medicare and is not homebound** – If the patient has Medicare and does not meet Medicare homebound requirements, you may bill Medicaid without billing Medicare first. Follow the instructions in that column of the Guide. Maintain documentation to support the determination that the patient is not homebound.

**Home Health Aide Visits:** Other than the Medicare homebound requirement, Medicare and Medicaid have the same requirements for home health aide visits. The only justification for billing Medicaid for a dually-eligible patient is that the patient does not qualify for a Medicare skilled service. HCPCS codes are not required for billing home health aide visits. Whenever you bill Medicaid for a dually-eligible patient, you are stating that you are billing for only those services allowed by Medicaid policy as described in the Guide.

- **For Medicaid only patients receiving Medicaid Home Health skilled services** – Bill home health aide visits using revenue code 570.

- **For dually-eligible patients who need home health aide services and qualify for MEDICARE-covered skilled home health services** – Bill home health aide visits to Medicare.

#### **Medical Supplies**

- **For a dually-eligible patient who needs medical supplies and qualifies for a MEDICARE-covered skilled home health service** – Bill the supplies to Medicare.
- **For all other patients** – Bill covered medical supplies using revenue code 270, plus the applicable HCPCS code for each supply item. The HCPCS codes are in the Medicaid Home Health Fee Schedule.

**REMEMBER:** In addition to being concerned about possible Medicare coverage, you must also determine if there are other third party payers to be billed before Medicaid.

### **5.10.2 Units of Service**

**Skilled Nursing, Therapies and Home Health Aide Services:** These services are billed by the visit. See 5.7 for guidance related to visits.

**Medical Supplies:** Supplies are paid by item according to the quantity provided. Note that some items are priced individually as well as by the package. Also, some items included in kits are priced individually as well. In either instance, your agency should provide and bill for such items in the most cost-effective manner.

### **5.10.3 Payment Rate**

Your payment is the lower of:

- Your billed usual and customary charge.
- Medicaid's maximum allowable rate.

### **5.10.4 Filing a Claim**

Use the UB-92 for your claim. Follow the claims filing instructions in Section 14.

**REMEMBER:** Use revenue codes and HCPCS codes for skilled nursing visits claims with dates of service 2/1/2000 and after.

**MEDICARE-Medicaid Skilled Services Billing Guide**

Skilled Nursing Visits	If patient is Medicaid only	If patient has MEDICARE and is...	
		Homebound	Not Homebound
<b>A. Evaluation/Observation</b>			
1. For initial observation and evaluation, teaching of a new diet regimen and/or compliance with new medications, and signs and symptoms of the disease state for a patient with an acute exacerbation of a pre-existing condition that required a recent acute hospitalization. The patient has been discharged from the hospital with documented clinical evidence of the recent acute exacerbation and there are multiple changes in medications.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
2. For observation and evaluation of a patient admitted to home health because of a reasonable potential for a complication or further acute episodes for three weeks or longer. Skilled nursing coverage beyond three weeks is generally not allowed if there is no modification of treatment or initiation of additional medical procedures, or evidence that abnormal or fluctuating clinical signs and symptoms are occurring.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
3. For evaluation of a pre-existing condition that causes the care of a current condition to become more complex.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
4. For observation and evaluation after a period with no significant changes in intervention. The patient's illness has reached a plateau. There is a chronic condition that is considered "stable" – no recent exacerbations, no recent changes in the medication or treatment regimen – yet there continues to be a documented medical necessity for intermittent nursing visits. Scheduled visits are limited to no more than one visit per calendar month. One PRN visit that is properly quantified and qualified on the physician's orders may be billed between scheduled visits.  <i>NOTE: When a need for intervention is identified, MEDICARE becomes the primary payer.</i>	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9952</i>	<i>You may bill Medicaid using the appropriate revenue code  Beginning 2/1/2000 date of service also use HCPCS code W9952</i>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9952</i>

**MEDICARE-*Medicaid* Skilled Services Billing Guide - Continued**

Skilled Nursing Visits - <i>Continued</i>	If patient is Medicaid only	If patient has MEDICARE and is...	
		Homebound	Not Homebound
<b>B. Teaching/Training</b>			
1. For teaching or training activities required to teach a patient and the patient's family/caregiver how to manage the patient's treatment regimen. The teaching/training are reasonable and necessary to the patient's illness or injury.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
2. For teaching the self-administration and self-management of a specific condition, such as diabetes.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
3. For reinforcement of teaching that had been provided in a controlled institutional setting. A limited number of skilled nursing visits are allowed to ensure that the patient and the patient's family/caregiver can transfer the teaching to a non-controlled environment.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
4. For retraining a patient when there has been a change in procedure or in the patient's condition that requires re-teaching; or when the patient and/or the patient's family/caregiver is not properly carrying out the task.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>

**MEDICARE-*Medicaid* Skilled Services Billing Guide - *Continued***

Skilled Nursing Visits - <i>Continued</i>	If patient is Medicaid only	If patient has MEDICARE and is...	
		Homebound	Not Homebound
<b>B. Teaching/Training – <i>Continued</i></b>			
5. For training a new caregiver.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
<b>C. Treatment</b>			
1. For insulin injections to a patient who is either physically and/or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
2. For administration of intravenous, intramuscular or subcutaneous injections and infusions when the medication being administered is accepted as the safe and effective treatment of a patient's illness or injury, and there is a medical reason that the medication cannot be taken orally.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
3. For providing IV antibiotic therapy to a patient with a diagnosis of osteomyelitis.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>

**MEDICARE-*Medicaid* Skilled Services Billing Guide - *Continued***

Skilled Nursing Visits - <i>Continued</i>	If patient is Medicaid only	If patient has MEDICARE and is...	
		Homebound	Not Homebound
<b>C. Treatment – <i>Continued</i></b>			
4. For ostomy care during the post-operative period and in the presence of associated complications.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
5. For changing or replacing tubes such as indwelling Foley catheters, gastrostomy tubes, supra-pubic tubes and nasogastric tubes.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
6. For prefilling insulin syringes if the patient has a qualifying MEDICARE home health service. <i>Visits are limited to no more than one visit per calendar week.</i>	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9953</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
7. For B-12 injections for the following conditions only: a. Pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia. b. Gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis and blind loop syndrome. c. Postlateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of neuropathy due to malnutrition and alcoholism.	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>

**MEDICARE-Medicaid Skilled Services Billing Guide - Continued**

Skilled Nursing Visits - <i>Continued</i>	If patient is Medicaid only	If patient has MEDICARE and is...	
		Homebound	Not Homebound
<b>C. Treatment – Continued</b>			
8. For prefilling insulin syringes if the patient does not have a qualifying MEDICARE home health service and there is not a willing and able caregiver to do so. <i>Visits are limited to no more than one visit per calendar week.</i>	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9953</i>	<i>You may bill Medicaid using the appropriate revenue code</i>  <i>Beginning 2/1/2000 date of service also use HCPCS code W9953</i>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9953</i>
9. For prefilling medication dispensers (“mediplanners”) and monitoring medication compliance after a period of time when the patient or caregiver has not been able to comprehend teaching and there is not a willing and able caregiver to do so. <i>Visits are limited to no more than one visit per calendar week.</i>	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9954</i>	<i>You may bill Medicaid using the appropriate revenue code</i>  <i>Beginning 2/1/2000 date of service also use HCPCS code W9954</i>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9954</i>
10. For administering prescribed oral medications, or providing skilled observation and monitoring the administration of eye drops when the complexity of the patient’s condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a nurse to detect and evaluate side effects or reactions. <b>NOTE: Neither Medicare nor Medicaid covers routine administration.</b>	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9957</i>	<b>BILL MEDICARE</b>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</i>
11. For “one-time” visits to provide a skilled service such as suture removal <b><i>in the absence of another qualifying skilled service.</i></b>	Use appropriate revenue code to bill Medicaid  <i>Beginning 2/1/2000 date of service also use HCPCS code W9956</i>	<i>You may bill Medicaid using the appropriate revenue code</i>  <i>Beginning 2/1/2000 date of service also use HCPCS code W9956</i>	<i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9956</i>

**MEDICARE-Medicaid Skilled Services Billing Guide - Continued**

Skilled Nursing Visits - Continued	If patient is Medicaid only	If patient has MEDICARE and is...	
		Homebound	Not Homebound
<b>C. Treatment – Continued</b>			
<p>12. For venipuncture when collection of a specimen is necessary for diagnosis and treatment of a patient's illness or injury; and when venipuncture cannot be performed in the course of regularly scheduled absences from the home to acquire medical treatment.</p> <p>a. The physician's order for the venipuncture for a laboratory test must be associated with a specific symptom or diagnosis, and the treatment must be recognized in the PDR or other authoritative source as being reasonable and necessary for the treatment of the illness or injury.</p> <p>b. The frequency of testing must be consistent with accepted standards of medical practice for continued monitoring of a diagnosis, medical problem or treatment regimen. Even when the laboratory results are consistently stable, periodic venipuncture may be reasonable and necessary because of the nature of the treatment.</p> <p>Examples of reasonable and necessary venipunctures for stabilized patients include, but are not limited to the following:</p> <ul style="list-style-type: none"> <li>• Venipuncture to monitor white blood cell count and differential count every three months for patients taking Captopril when the results are stable and the patient is asymptomatic.</li> <li>• Venipuncture for phenytoin (e.g., Dilantin) levels every three months when the results are stable and the patient is asymptomatic.</li> <li>• Venipuncture to monitor complete blood count as ordered by a physician for patients receiving chemotherapy at home.</li> <li>• Venipuncture for fasting blood sugar ("FBS") once every two to three months for a stable diabetic.</li> <li>• Venipuncture for prothrombin ("pro-time") monthly when the results are stable within the therapeutic range.</li> </ul> <p>The medical necessity for venipuncture visits that do not fall within the above must be fully substantiated in your records.</p> <p><b>REMEMBER: You may not bill Medicaid for a venipuncture visit if the task may be covered under MEDICARE.</b></p>	<p>Use appropriate revenue code to bill Medicaid</p> <p><i>Beginning 2/1/2000 date of service also use HCPCS code W9955</i></p>	<p><b>BILL MEDICARE if the patient has a Medicare-qualifying service</b></p> <p><i>You may bill Medicaid in the absence of a Medicare-qualifying service. Use the appropriate revenue code</i></p> <p><i>Beginning 2/1/2000 date of service also use HCPCS code W9955</i></p>	<p><i>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9955</i></p>

**MEDICARE-Medicaid Skilled Services Billing Guide - Continued**

Skilled Nursing Visits - Continued	If patient is Medicaid only	If patient has MEDICARE and is...	
		Homebound	Not Homebound
<b>C. Treatment - Continued</b>			
<p>13. For wound care when the skills of a licensed nurse are needed to provide the care safely and effectively. The care may include direct, hands-on treatment; teaching of care; and/or skilled observation and assessment. The following characteristics generally substantiate that the skills of a licensed nurse are reasonable and necessary:</p> <ul style="list-style-type: none"> <li>a. Open wounds that are draining purulent or colored exudate, or that have a foul odor present and/or for which the patient is receiving antibiotic therapy.</li> <li>b. Wounds with a drain or T-tube that requires shortening, or movement of such drains.</li> <li>c. Recently debrided ulcers.</li> <li>d. Pressure sores when there is a partial tissue loss with signs of infection, or there is a full thickness tissue loss that involves exposure of fat or invasion of other tissues such as muscle or bone.</li> <li>e. Wounds with exposed internal vessels or a mass that may have proclivity for hemorrhage when a dressing is changed.</li> <li>f. Open wounds or widespread skin complications following radiation therapy, or that result from immune deficiencies or vascular insufficiencies.</li> <li>g. Post-operative wounds where there are complications such as infection or allergic reaction, or where there is underlying disease that has a reasonable potential to adversely affect healing.</li> <li>h. Third degree burns, and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed.</li> <li>i. Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present significant risk to the patient.</li> <li>j. Other open and complex wounds that require treatment that can be safely and effectively provided only by a licensed nurse.</li> </ul> <p><b>NOTE:</b> Although healing may not be a realistic goal, continued wound care is covered under MEDICARE guidelines as long as the patient is homebound, the skilled care is needed – that is, the documentation supports reasonable potential for complications or ineffective healing – and the wound care frequency meets the intermittent criteria for MEDICARE coverage.</p>	<p>Use appropriate revenue code to bill Medicaid</p> <p>Beginning 2/1/2000 date of service also use HCPCS code W9957</p>	<b>BILL MEDICARE</b>	<p>Beginning 10/1/2000 date of service, you may bill Medicaid using the appropriate revenue code plus HCPCS code W9959</p>

**MEDICARE-Medicaid Skilled Services Billing Guide - Continued**

Physical Therapy Visits	If patient is Medicaid only	If patient has MEDICARE and is...	
		Homebound	Not Homebound
1. For patients with conditions that will improve materially in a reasonable and generally predictable period of time.	Use revenue code 420 to bill Medicaid	<b>BILL MEDICARE</b>	<b>You may use</b> revenue code 420 to bill Medicaid
2. For evaluating the overall needs, selecting the appropriate equipment and/or teaching safe transfer techniques to a patient who has recently experienced an exacerbation of his condition that has resulted in a decreased level of functioning.	Use revenue code 420 to bill Medicaid	<b>BILL MEDICARE</b>	You may bill Medicaid using revenue code 420
3. For patients who have achieved partial restoration of function, but are not expected to achieve further measurable or functional gains; however, the patient has a significant potential for loss of strength, endurance, range of motion/flexibility, or mobility (due to abnormal muscle tone, behavioral components or other factors) which could result in deterioration of the patient's physical status.	Use revenue code 420 to bill Medicaid	You may bill Medicaid using revenue code 420	You may bill Medicaid using revenue code 420
4. For establishing a maintenance program.	Use revenue code 420 to bill Medicaid	<b>BILL MEDICARE</b>	You may bill Medicaid using revenue code 420
5. For gait evaluation and training for a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality if the services will materially improve the patient's ability to walk.	Use revenue code 420 to bill Medicaid	<b>BILL MEDICARE</b>	You may bill Medicaid using revenue code 420
6. For exercise and functional activity program in order to maintain or retard deterioration of physical ability.	Use revenue code 420 to bill Medicaid	You may bill Medicaid using revenue code 420	You may bill Medicaid using revenue code 420
7. For teaching the patient and the patient's family/caregiver the necessary techniques, exercises and/or precautions that are reasonable and necessary to treat a recent acute episode or exacerbation of an illness or injury.	Use revenue code 420 to bill Medicaid	<b>BILL MEDICARE</b>	You may bill Medicaid using revenue code 420
8. For a patient who has been discharged from a hospital following a recent hip fracture and has an unsafe gait and restricted mobility. The patient has not been instructed in stair climbing or in a home exercise program, and previously had a functional capacity for full mobility, ambulation and self-care.	Use revenue code 420 to bill Medicaid	<b>BILL MEDICARE</b>	You may bill Medicaid using revenue code 420

**MEDICARE-*Medicaid* Skilled Services Billing Guide - *Continued***

<b>Physical Therapy Visits – <i>Continued</i></b>	<b>If patient is Medicaid only</b>	<b>If patient has MEDICARE and is...</b>	
		<b>Homebound</b>	<b>Not Homebound</b>
9. For evaluation of a pre-existing condition that causes the care of a current condition to become more complex.	Use revenue code 420 to bill Medicaid	<b>BILL MEDICARE</b>	<i>You may bill Medicaid using revenue code 420</i>
10. For maintaining range of motion as part of an active treatment program for a specific disease state, illness, or injury that has resulted in restricted mobility or when the patient has medical complications (e.g., susceptibility to pathological fractures or soft tissue damage) which require the skills of a licensed therapist to complete range of motion exercises.	Use revenue code 420 to bill Medicaid	<b>BILL MEDICARE</b>	<i>You may bill Medicaid using revenue code 420</i>

**MEDICARE-Medicaid Skilled Services Billing Guide - Continued**

Occupational Therapy Visits	If patient is Medicaid only	If patient has MEDICARE and is...	
		Homebound	Not Homebound
<p>1. For a <i>dually-eligible</i> patient who's eligibility for MEDICARE Home Health coverage has been established by a prior need for skilled nursing care, speech-language pathology services, or physical therapy in the current or prior certification period; and has a need for:</p> <ul style="list-style-type: none"> <li>a. An assessment/reassessment of rehabilitation needs and potential;</li> <li>b. The development and/or implementation of an occupational therapy program, including, but not limited to: <ul style="list-style-type: none"> <li>(1) Selecting and teaching task oriented therapeutic activities designed to restore physical function.</li> <li>(2) Planning, implementing and supervising therapeutic tasks and activities designed to restore sensory-integrative function.</li> <li>(3) Planning, implementing and supervising of individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness.</li> <li>(4) Teaching compensatory techniques to improve the level of independence in the activities of daily living.</li> <li>(5) The designing, fabricating, and fitting of orthotic and self-help devices.</li> <li>(6) Vocational and prevocational assessment and training that is directed toward the restoration of function in the activities of daily living lost due to illness or injury (activities related solely to specific employment activities, work skills or work settings are not covered as they are not directly related to treatment).</li> </ul> </li> </ul>	Not Applicable – see 3. below	<b>BILL MEDICARE</b>	<b>Not Applicable – see 2. below</b>
<p>2. For a <i>dually-eligible</i> patient who needs the occupational therapy services described in 1. above, but who's eligibility for MEDICARE Home Health coverage has not been established by a prior need for skilled nursing care, speech-language pathology services, or physical therapy in the current or prior certification period.</p>	Not Applicable – see 3. below	You may bill Medicaid using revenue code 430	You may bill Medicaid using revenue code 430
<p>3. For a Medicaid only patient who needs the occupational therapy services described in 1. above.</p>	Use revenue code 430 to bill Medicaid	<b>Not Applicable</b>	<b>Not Applicable</b>

**MEDICARE-Medicaid Skilled Services Billing Guide - Continued**

Speech-Language Pathology Visits	If patient is Medicaid only	If patient has MEDICARE and is...	
		Homebound	Not Homebound
<p>1. For a patient who has a need for speech-pathology services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. Usual situations in which the coverage applies include the following:</p> <p>a. The skills of a speech-language pathologist are required for the assessment of a patient's rehabilitation needs (including the causal factors and the severity of the speech and language disorders), and rehabilitation potential. Reevaluation would only be considered reasonable and necessary if the patient exhibited a change in functional speech or motivation, clearing of confusion or the remission of some other medical condition that previously contraindicated speech-language pathology services. Where a patient is undergoing restorative speech-language pathology services, routine reevaluations are considered to be a part of the therapy and could not be billed as a separate visit.</p> <p>b. The services of a speech-language pathologist would be covered if they are needed as a result of an illness or injury and are directed towards specific speech/voice production.</p> <p>c. Speech-language pathology would be covered where the service can only be provided by a speech-language pathologist and where it is reasonably expected that the service will materially improve the patient's ability to independently carry out any one or combination of communicative activities of daily living in a manner that is measurably at a higher level of attainment than that prior to the initiation of the services.</p> <p>d. The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks and cueing that directs a patient toward speech-language communication goals in the plan of care would be covered speech-language pathology services.</p>	Use revenue code 440 to bill Medicaid	<b>BILL MEDICARE</b>	<i>You may bill Medicaid using revenue code 440</i>

**MEDICARE-Medicaid Skilled Services Billing Guide - Continued**

Speech-Language Pathology Visits – <i>Continued</i>	If patient is Medicaid only	If patient has MEDICARE and is...	
		Homebound	Not Homebound
<p>e. The services of a speech-language pathologist to train the patient, family or other caregivers to augment the speech-language communication treatment, or to establish an effective maintenance program would be covered speech-language pathology services.</p> <p>f. The services of a speech-language pathologist to assist patients with aphasia in rehabilitation of speech and language skills are covered when needed by a patient</p>	Use revenue code 440 to bill Medicaid	<b>BILL MEDICARE</b>	<i>You may bill Medicaid using revenue code 440</i>
2. The services of speech-language pathologist to assist patients with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production are covered when needed by a patient. For a patient with dysphagia who has achieved partial restoration of function, but is not expected to experience further measurable gains from active treatment; however, the patient has a significant potential for loss of functional swallowing resulting in deterioration of the patient's oral intake. Visits are needed solely to review and upgrade food consistencies. Usually, the need is expected to be met within one certification period and involve no more than six visits (two to three per month in one certification period).	Use revenue code 440 to bill Medicaid	<i>You may bill Medicaid using revenue code 440</i>	<i>You may bill Medicaid using revenue code 440</i>
3. For a patient with apraxia who has achieved partial restoration of function, but is not expected to experience further measurable gains from active treatment; however, the patient has a significant potential for loss of functional communication. Visits are needed solely to review and upgrade a communication home program. Usually, the need is expected to be met within one certification period and involve no more than nine visits (one per week).	Use revenue code 440 to bill Medicaid	<i>You may bill Medicaid using revenue code 440</i>	<i>You may bill Medicaid using revenue code 440</i>

## Home Health Services Q & A

The following includes some of the common questions about providing Home Health Services and the answers to those questions. They are divided into the following categories according to the emphasis of the question:

- Supplies
- Dually-eligible patients
- Home health aide
- Coding and documentation
- Services to CAP participants
- “Homebound” (these questions relate to Medicaid deletion of the “homebound” requirement in October 2000)

### Supplies

- S1. Q.** Our home health agency has been contacted by a Medicaid patient who needs medical supplies. No other home health service is required. Can our agency provide this patient with medical supplies?
- A.** Yes. A Medicaid patient may receive medical supplies from a home health agency, even when no other Home Health Services are needed. The patient must be a client of the agency and have a plan of care established by a physician
- S2. Q.** Do home health agencies have to make skilled nursing visits every 60 days to a patient who receives only medical supplies? If so, what code should be used to describe the visits and what documentation is required on the HCFA-485?
- A.** A RN must make a reassessment visit to a patient's home at least every 60 days to ensure that the patient is receiving the appropriate medical supplies. The HCFA-485 must indicate that the skilled nursing visit is to assess the appropriateness of home health supplies. If the patient is receiving skilled nursing under Medicare or Medicaid, the assessment would be made during that visit and a separate visit should not be billed to Medicaid to assess supply needs. A separate visit is made only if the patient is receiving no other services except supplies – use HCPCS Code W9958 (Home Health skilled nursing visit not otherwise classified) to bill such visits.
- S3. Q.** Our home health agency has a patient who receives only medical supplies. Can we be paid for a skilled nursing visit to deliver these supplies to the patient once every 30 days?
- A.** No. Medicaid does not pay a home health agency for skilled nursing visits to deliver medical supplies.
- S4. Q.** When is it appropriate to bill for non-sterile gloves?
- A.** The policy on Home Health medical supplies is in 5.1.6. You first have to determine whether the gloves are being used as protective barriers (such as for OSHA requirements) or if the gloves are being used for physician ordered medical treatments.

*If the gloves are used as protective barriers, the following applies:*

- a. Home health agencies may provide non-sterile gloves to family members and similar caregivers to carry out transmission-based precautions (formerly "universal precautions") only if the caregiver is in contact with the patient's blood or other potentially infectious body fluids. The primary focus is on hepatitis B and HIV. The gloves must be specifically ordered by the physician with those conditions cited.
- b. Non-sterile gloves are not covered for family members and similar caregivers for routine personal and related care, such as wearing gloves to give a bath or to handle soiled linen or clean a bedside commode, in the absence of the above conditions.

- c. Non-sterile gloves are considered routinely a part of patient care when used by a provider and are considered an overhead cost. Non-sterile gloves to meet OSHA requirements are not covered.
- d. Home health agencies may not provide non-sterile gloves for use by adult care homes, such as rest homes, to meet OSHA requirements.

*If the gloves are for physician ordered medical treatments, the following applies:*

- a. Home health agencies may provide gloves to family members and caregivers to carry out specifically ordered treatments, such as dressing changes, suctioning or in and out catheterizations utilizing clean technique. The gloves must be specifically ordered by the physician. The supply would be covered for a rest home patient just like other supplies specifically for a medical treatment.
- b. Non-sterile gloves for use by home health agency staff to carry out specifically ordered treatments, such as dressing changes, suctioning or in and out catheterizations utilizing clean technique, are covered. Again, the gloves must be specifically ordered by the physician as part of the plan of treatment.

- S5. Q.** Our agency has received requests to supply disposable diapers for newborns. What is the guidance for providing these items for young children?
- A.** Disposable diapers must be medically necessary to be billed to Medicaid. Until two to three years of age, children wear diapers regardless of their medical condition. Rarely would it be justifiable to bill Medicaid for diapers for a child who is at an age when diapers are normally worn.
- S6. Q.** The physician ordered a “Sween Cream” type of protective skin barrier for the patient. May we bill this to W4655?
- A.** No. Skin creams and lotions are not covered by Medicaid.
- S7. Q.** My patient had knee replacement surgery and the physician ordered compression hose. May these be billed to W4655?
- A.** Yes, when there is documented medical necessity.
- S8. Q.** The physician ordered an enteral nutrition supplement for my patient. Is it okay to bill this to W4655?
- A.** Enteral nutrition products may not be billed as a Home Health supply. Medicaid covers these products under the DME and HIT programs.
- S9. Q.** May Proderm be billed to W4655?
- A.** No. Proderm is already listed under “Skin Care (Decubitus) Supplies.” Supplies must be billed using their assigned codes.
- S10. Q.** I have a patient who has difficulty brushing his teeth. Are glycerin swabs and toothettes billable?
- A.** No. Glycerin swabs and toothettes are considered comfort or convenience items that lack medical necessity.
- S11. Q.** None of the ostomy pouches on the supply list are suitable for the preemie patients I see. May we bill a smaller pouch and use W4655?
- A.** Yes, as long as there is supporting documentation showing that the smaller pouch is medically necessary.
- S12. Q.** We have several insulin-dependent diabetics that need cotton balls when they inject. May we bill these to W4655?
- A.** No. Cotton balls are considered an overhead cost and may not be billed separately.

- S13. Q.** The supply list includes disposable diapers and pullups. May we use W4655 to bill for “Poise Pads” or panty liners?
- A.** These items are considered a comfort or convenience item and are not billable to W4655.
- S14. Q.** The physician ordered Ensure pudding and bars for the patient. May we bill them to W4655?
- A.** No. Oral nutritional supplements in any form are not billable as a Home Health supply.
- S15. Q.** If a patient receives Medicare skilled services, and diapers are being billed to Medicaid, what documentation is required?
- A.** Since Medicare covers only diapers that are used during a home health visit, documentation on the HCFA-485 must show that diapers billed to Medicaid are for the patient’s use between visits billed to Medicare.
- S16. Q.** If a patient needs a supply item that is not on the list of Medicare Prospective Payment System (PPS) bundled items, could Medicaid be billed for that item?
- A.** Medicaid billing guidance has not changed. If it can be accurately documented that Medicare does not cover a home health supply item that meets Medicaid coverage criteria, then providers may bill Medicaid. It is DMA’s understanding that Medicare has a list of procedure codes bundled into the PPS rate. Medicare has stated that the list is not all-inclusive and that other supply items may also be considered part of the payment.
- S17. Q.** What if the patient is a CAP participant? Doesn’t that make a difference in Home Health supplies that are covered?
- A.** No. CAP participants must meet the same coverage requirements for Home Health supplies. There are no exceptions for CAP participants.

**Dually-Eligible Patients** (*also see S2, S15, S16, CD1, CD2, and C2*)

- DE1. Q.** We have a dually-eligible patient who meets Medicare homebound criteria and has been getting Medicare coverage for skilled nursing visits for wound care. Our documentation supports that wound care no longer meets Medicare criteria. Which code should be used to bill Medicaid?
- A.** In rare cases when Medicare does not cover wound care for a Medicare homebound patient, use W9958 (Home Health skilled nursing visit not otherwise classified). Before billing Medicaid, pay special attention to instructions in the note in C.13 on the *MEDICARE-Medicaid Skilled Services Billing Guide*.
- DE2. Q.** Would payments for Medicaid Personal Care Services (PCS) for a dually eligible patient receiving skilled services and home health aide services under Medicare PPS be allowed?
- A.** The home health agency is responsible for providing all covered home health needs under Medicare PPS during an open episode. While Medicaid does not have a policy directly prohibiting a patient from receiving PCS and home health aide services – as long as the services are not provided on the same day – Medicaid would question why PCS was being provided since both services cover the same tasks. PCS should not replace care that is covered under Medicare.
- DE3. Q.** Are two HCFA-485s required if a dually eligible patient is receiving skilled nursing (such as venipuncture) under Medicaid and therapy services under Medicare?
- A.** Medicaid does not require a separate HCFA-485. There may be several payers and the provider is responsible for determining which payer should be billed for each documented service.

**DE4. Q.** When a non-homebound dually eligible patient has Medicare Part B covering outpatient therapies, would Medicaid home health therapy services be appropriate?

- A.** See Section 5.2.3. The criteria must be applied to determine the most appropriate setting regardless of any other reimbursement source. For example, if it can be documented that the patient lives in an area where travel to outpatient therapy would require an hour or more of travel and this would interfere with the effectiveness of the service, Medicaid may be considered.

**Home Health Aide** (*also see DE2*)

**A1. Q.** I have received a request to provide home health aide services to a patient in a rest home. May I bill Medicaid for these services?

- A.** No. Medicaid does not pay for home health aide services to a patient in an adult care home such as a rest home.

**A2. Q.** Does a home health agency professional have to make an assessment visit prior to the first aide visit?

- A.** Yes, an agency professional, whether a RN or licensed therapist, must make an assessment visit to determine a patient's needs before aide services begin.

**Coding and Documentation**

**CD1. Q.** If more than one skilled nursing task/activity described on the *MEDICARE-Medicaid Skilled Services Billing Guide* is provided during the same visit, such as prefilling a medi-planner and prefilling insulin syringes, which code is used?

- A.** First, determine if either activity meets Medicare coverage guidelines. If so, bill the visit to Medicare. If Medicare does not cover the visit, then determine which Medicaid HCPCS code to use based on the code that describes the most important skilled nursing activity in relation to the patient's health and well-being. If the activities appear equal in importance, use your best judgement to select the code. The HCFA-485 and your clinical documentation should support your HCPCS code selection.

**CD2. Q.** Since Medicare now has a 60-day recertification period for each episode, will DMA accept documented orders such as "SN 2-visits over next 60 days?"

- A.** Yes. Providers should consult the *MEDICARE-Medicaid Skilled Services Billing Guide* for the frequencies allowed for skilled nursing visits.

**Services to CAP Participants** (*also see S17*)

**C1. Q.** As a home health agency, we get referrals for monthly skilled nursing visits for CAP/DA participants. Occasionally, we have a patient referred who we believe does not meet Medicaid Home Health criteria. The CAP case manager tells us that the monthly skilled nursing visit is required for CAP/DA participants; therefore, it is a covered service. Similarly, we get referrals for therapy services for CAP-MR/DD clients who do not meet the Medicaid Home Health criteria. The CAP-MR/DD case manager states that the clients are exempt from the criteria because they are on CAP-MR/DD. May we bill Medicaid for Home Health Services to CAP recipients who do not meet the Home Health criteria in Section 5 of the *Community Care Manual*?

- A.** No. In order for someone in CAP/DA, CAP-MR/DD, CAP/C or CAP/AIDS to get a regular Medicaid community care service such as Home Health, DME or PDN, the individual must meet the same requirements for those services as other Medicaid recipients – there is no exemption for CAP participants. If a home health agency believes that a referred patient does not meet the requirements for a skilled service (skilled nursing, physical therapy, occupational therapy or speech-language pathology services) or home health aide services under Home Health, the home health agency must not accept the patient as a Medicaid patient.

In regard to CAP/DA, the CAP/DA case manager has instructions in the CAP/DA Manual to contact DMA's CAP Unit for guidance when a CAP/DA participant does not qualify for Home Health skilled

nursing visits. Failing to qualify for a monthly skilled nursing visit will not exclude the patient from CAP/DA.

CAP-MR/DD participants are not exempt from meeting Medicaid's Home Health requirements. In regard to therapies, Medicaid pays for PT, OT and speech pathology services through sources other than Home Health, including area MH/DD/SA programs, outpatient services and the Independent Practitioner Program for children.

- C2. Q.** Our agency provides monthly skilled nursing visits to CAP/DA clients – which we refer to as “CAP assessment visits.” What HCPCS code should be used?
- A.** Medicaid guidelines do not include a service identified as a “CAP assessment.” Home Health services to CAP clients are based on the same criteria used for all Medicaid recipients. There are no special exemptions or allowances for CAP recipients. When billing for a skilled nursing visit, determine if the purpose of the visit is described on the *MEDICARE-Medicaid Skilled Services Billing Guide*. If Medicare covers the visit, bill Medicare. When Medicare does not cover the visit, determine if the visit is medically necessary and the home is the most appropriate setting in accordance with the guidelines in Section 5.2.3. If the patient qualifies for Medicaid Home Health coverage, determine the purpose of the skilled nursing visit using the Guide to determine the appropriate HCPCS code. If the visit is for observation and evaluation after a period with no significant changes in intervention – the patient’s condition is chronic but stable yet there continues to be a documented medical necessity for intermittent nursing visits – W9952 is the appropriate code and the limits in the Guide apply. When a need for a Medicare-covered intervention is identified and the patient meets Medicare homebound requirements, Medicare becomes the primary payer.

**“Homebound”** (*these questions relate to Medicaid’s deletion of the “homebound” requirement in October 2000*)

- H1. Q.** Does Medicaid policy allow patients attending adult day facilities for therapeutic or psychosocial reasons to receive home health services in their place of residence?
- A.** Unlike the former Medicaid homebound criteria, the provision of home health services is not related to the patient’s absence from home. Under the guidance issued 10/2000, skilled services and home health aide services must be medically necessary and appropriate in the home setting and meet the requirements in Section 5.2.3.
- H2. Q.** May Medicaid be billed for a skilled nursing visit for observation and evaluation of a chronically ill patient if the patient makes a monthly office visit to the physician for medication, etc.?
- A.** Skilled nursing visits billed to Medicaid must be medically necessary and the home deemed the most appropriate setting for the care. Since the patient is being seen in the physician’s office on a monthly basis, a skilled nursing visit for observation and evaluation in the patient’s home would not meet Medicaid requirements.

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